

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16974

State File No.

FILED JUN 7 1943

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2403

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
4536 Genesee
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 50 yrs (Specify whether years, months or days)

3. (a) PRINT FULL NAME Anna S. Holmberg

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race Wh 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife John A. Holmberg 6. (c) Age of husband or wife if alive Deceased

7. Birth date of deceased October 16, 1861
(Month) (Day) (Year)

8. AGE: Years 81 Months 7 Days 10 If less than one day hr. min.

9. Birthplace No Record Sweden
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Self

12. Name No Record

13. Birthplace No Record Sweden
(City, town, or county) (State or foreign country)

14. Maiden name Anna Sophia Johnson

15. Birthplace No Record Sweden
(City, town, or county) (State or foreign country)

16. (a) Informant Miss Hanna Holmberg

(b) Address 4536 Genesee

17. (a) Burial (b) Date thereof 5/28/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Moriah Cem.

18. (a) Signature of funeral director Safe Funeral Home

(b) Address 1901 Olaths Blvd. K.C. Kans.

19. (a) 5-26-43 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 4536 Genesee
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 26th year 1943 hour 2 minute 45 A.M.

21. I hereby certify that I attended the deceased from May 6 to May 25, 1943, that I last saw her alive on May 24, 1943, and that death occurred on the date and hour stated above. Immediate cause of death Exhaustion

Due to Subacute Bacterial Endocarditis

Due to Cause Unknown

Other conditions (Include pregnancy within 3 months of death) 9/a

Major findings: Of operations

Of autopsy

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) Means of injury

23. Signature G. L. Moore (M. D. or other) 80
Address 7810 N. 45 Date signed 5/26/43

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.
working under my personal supervision.

Signed.....

Licensed Embalmer No. 3991

P. O. Address..... 309 E 67 St.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.